Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss efforts to reform the administration, structure, and financing of Medicare—steps essential to maintaining the program's long-term sustainability and modernization. There appears to be an emerging consensus that substantive financing and programmatic reforms are necessary to put Medicare on a sustainable footing for the future. The long-term cost pressures facing this program are considerable. Fundamental program reforms are vital to reducing the program's growth, which threatens to absorb ever-increasing shares of the nation's budgetary and economic resources.

We stand at an important crossroads. After nearly 30 years of deficits, the combination of hard choices and remarkable economic growth has led to a budget surplus. We appear—at least for the near future—to have slain the deficit dragon. In its most recent projections, the Congressional Budget Office (CBO) shows both unified and on-budget surpluses throughout the next 10 years. While this is good news, it does not mean that hard choices are a thing of the past. First, it is important to recognize that by their very nature projections are uncertain. This is especially true today because, as CBO notes, it is too soon to tell whether recent boosts in revenue reflect a major structural change in the economy or a more temporary divergence from historical trends. Indeed, CBO points out that assuming a return to historical trends and slightly faster growth in Medicare would change the on-budget surplus to a growing deficit. This means we should treat surplus predictions with caution. Current projected surpluses could well prove to be fleeting, and thus appropriate caution should be exercised when creating new entitlements that establish permanent claims on future resources.

Moreover, while the size of future surpluses could exceed or fall short of projections, we know that demographic and cost trends will, in the absence of meaningful reform, drive Medicare spending to levels that will prove unsustainable for future generations of taxpayers. Accordingly, we need to view this period of projected prosperity as an opportunity to address the structural imbalances in Medicare, Social Security, and other entitlement programs before the approaching demographic tidal wave makes the imbalances more dramatic and more painful.

As the foregoing suggests, the stakes associated with Medicare reform are high for the program itself and for the rest of the federal budget, both now and for future generations. Current policy decisions can help us prepare for the challenges of an aging society in several important ways: (1) reducing public debt to increase national savings and investment, (2) reforming entitlement programs to reduce future claims and free up resources for other competing priorities, and (3) establishing a more sustainable Medicare program that delivers effective and affordable health care to our seniors.

In this context, I would like to make a few summary points before delving into the specifics of Medicare's financial health and a discussion of potential reforms.

- In addition to its sizable financial imbalance, Medicare is outmoded from a programmatic perspective. To address the need for an updated benefit package and adequate tools to moderate program spending, proposals have been advanced that include benefit expansions

and changes that make beneficiaries more cost conscious and incentives to make health care providers more efficient. This hearing focuses on one such proposal contained in S. 1895, entitled the Medicare Preservation and Improvement Act of 1999, which is commonly referred to as the Breaux-Frist proposal.

- Given the size of Medicare's unfunded liability, it is realistic to expect that reforms intended to bring down future costs will have to proceed incrementally. The time to begin the difficult but necessary steps to reclaim our fiscal future is now, when we have budget surpluses and a demographic "holiday" with retirees a far smaller proportion of the population than they will be in the future.

- Ideally, the unfunded promises associated with today's program should be addressed before or concurrent with proposals to make new ones, such as adding prescription drug coverage. To do otherwise might be politically attractive but not fiscally prudent. If benefits are added, policymakers need to consider targeting strategies that fully offset the related costs. They may also want to design a mechanism to monitor aggregate program costs over time and to establish expenditure or funding thresholds that would trigger a call for fiscal action. Our history shows that when benefits are attractive, fiscal controls and constraints are difficult to maintain. In addition, any potential program expansion should be accompanied by meaningful reform of the current Medicare program to help ensure its sustainability.

- To qualify as meaningful reform, a proposal should make a significant down payment toward ensuring Medicare's long-range financial integrity and sustainability—the most critical issue facing Medicare. The 1999 annual reports of the Medicare trustees project that program costs will continue to grow faster than the rest of the economy. Care must be taken to ensure that any potential expansion of the program is balanced with other programmatic reforms so that we do not worsen Medicare's existing financial imbalances. Proposals to reform Medicare should be assessed against the following criteria: affordability, equity, adequacy, feasibility, and acceptance. (See table 1.)

Table 1: Criteria for Assessing the Merits of Medicare Reform Proposals

Criterion	**What this means for a proposal**
Affordability	A proposal should be evaluated in terms of its effect on the long-term sustainability of Medicare expenditures
Equity	A proposal should be fair to providers and across groups of beneficiaries
Adequacy	A proposal should include resources that allow appropriate access and provisions that foster cost-effective and clinically meaningful innovations that address patients' needs
Feasibility	A proposal should incorporate elements that facilitate effective implementation and adequate monitoring
Acceptance	A proposal should be transparent and should educate provider and beneficiary communities about its costs and the realities of trade-offs required by significant policy changes

- People want unfettered access to health care, and some have needs that are not being met. However, health care costs compete with other legitimate priorities in the federal budget,

and their projected growth threatens to crowd out future generations' flexibility to decide which of these competing priorities will be met. Thus, in making important fiscal decisions for our nation, policymakers need to consider the fundamental differences between wants, needs, and what both individuals and our nation can afford. This concept applies to all major aspects of government, from major weapons system acquisitions to issues affecting domestic programs. It also points to the fiduciary and stewardship responsibility that we all share to ensure the sustainability of Medicare for current and future generations within a broader context of providing for other important national needs and economic growth.

- Let's not kid ourselves—reforming Medicare is hard work. Health care spending accounts for one-seventh of the nation's economy, and Medicare is the nation's single largest health care payer. The program's beneficiary populations consist of roughly 35 million seniors and 4 million disabled individuals under age 65. The Health Care Financing Administration (HCFA) estimates that the program's billers—physicians, hospitals, equipment suppliers, and other providers of health services—number about 1 million.

- As the various reform options come under scrutiny, the importance of design details should not be overlooked. Our work on efforts to implement reforms mandated in the BBA is instructive regarding reform specifics. Three principal lessons can be drawn from recent experience: (1) The particulars of payment mechanisms largely determine the extent to which a reform option can eliminate excess government spending while protecting beneficiaries access' to care. (2) Revisions to newly implemented policies should be based on a thorough assessment of their effects so that, at one extreme, they are not unduly affected by external pressures and premature conclusions or, at the other extreme, they remain static when change is clearly warranted. (3) For choice-based models to function as intended--that is, to foster competition based on cost and quality--consumers must have information that is sufficiently comparable.

At this time, I would like to discuss the competing concerns at the crux of Medicare reform in general, and to provide a conceptual framework for considering the various possible combinations of reform options in particular.

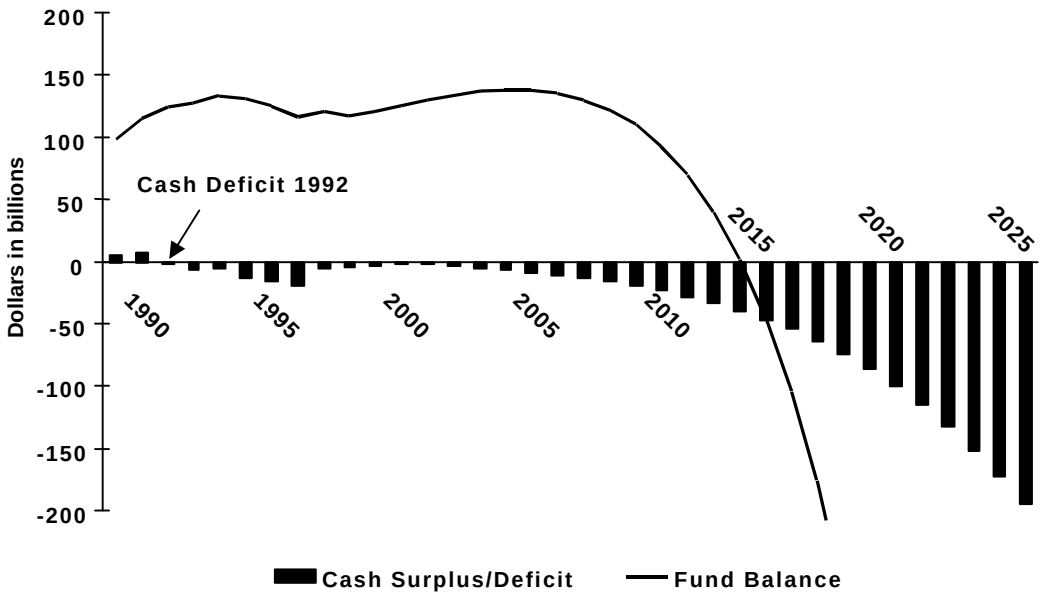
COMPETING CONCERNS POSE CHALLENGES FOR MEDICARE REFORM

The current Medicare program, without improvements, is ill suited to serve future generations of seniors and eligible disabled Americans. On the one hand, the program is fiscally unsustainable in its present form, as the disparity between program expenditures and program revenues is expected to widen dramatically in the coming years. On the other, the program is outmoded in that it has not been able to adopt modern, market-based management tools, and its benefit package contains gaps in desired coverage compared with private employer coverage. Compounding the difficulties of responding to these competing concerns is the sheer size of the Medicare program—even modest program changes send ripples across the program's 39-million-strong beneficiary population and the approximately 1 million health care providers that bill the program. Balancing the needs of all these parties requires hard choices.

Medicare Is Already in the Red

Unlike private trust funds that can set aside money for the future by investing in financial assets, the Medicare Hospital Insurance (HI) Trust Fund—which pays for inpatient hospital stays, skilled nursing care, hospice, and certain home health services—is essentially an accounting device. It allows the government to track the extent to which earmarked payroll taxes cover Medicare's HI outlays. In serving the tracking purpose, annual trust fund reports show that Medicare's HI component is, on a cash basis, in the red and has been since 1992. (See fig. 1.) Currently, earmarked payroll taxes cover only 89 percent of HI spending and, including all earmarked revenue, the fund is projected to have a $7 billion cash deficit for fiscal year 1999 alone. To finance this deficit, Medicare has been drawing on its special issue Treasury securities acquired during the years when the program generated a cash surplus. Consequently, Medicare is already a net claimant on the Treasury—a threshold that Social Security is not currently expected to reach until 2014. In essence, for Medicare to "redeem" its securities, the government must raise taxes, cut spending for other programs, or reduce the projected surplus. Outlays for Medicare services covered under Supplementary Medical Insurance (SMI)--physician and outpatient hospital services, diagnostic tests, and certain other medical services and supplies--are already funded largely through general revenues.

Figure 1: Financial Outlook of the Hospital Insurance Trust Fund, 1990 to 2025

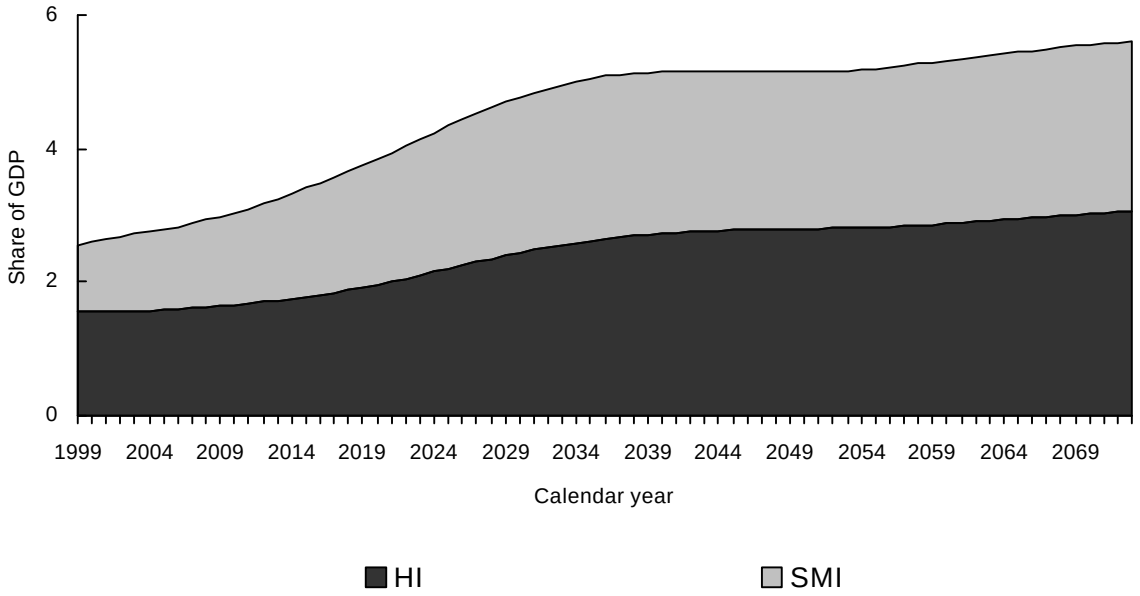


Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund.

Without meaningful reform, the long-term financial outlook for Medicare is bleak. Together, Medicare's HI and SMI expenditures are expected to increase dramatically, rising from 12 percent in 1999 to more than a quarter of all federal revenues by midcentury. Over the same

time frame, Medicare's expenditures are expected to double as a share of the economy, from 2.5 to 5.3 percent, as shown in figure 2.

Figure 2: Medicare Spending as a Percentage of Gross Domestic Product (GDP), 1999 to 2073



Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund and *1999 Annual Report*, Federal Supplementary Insurance Trust Fund.

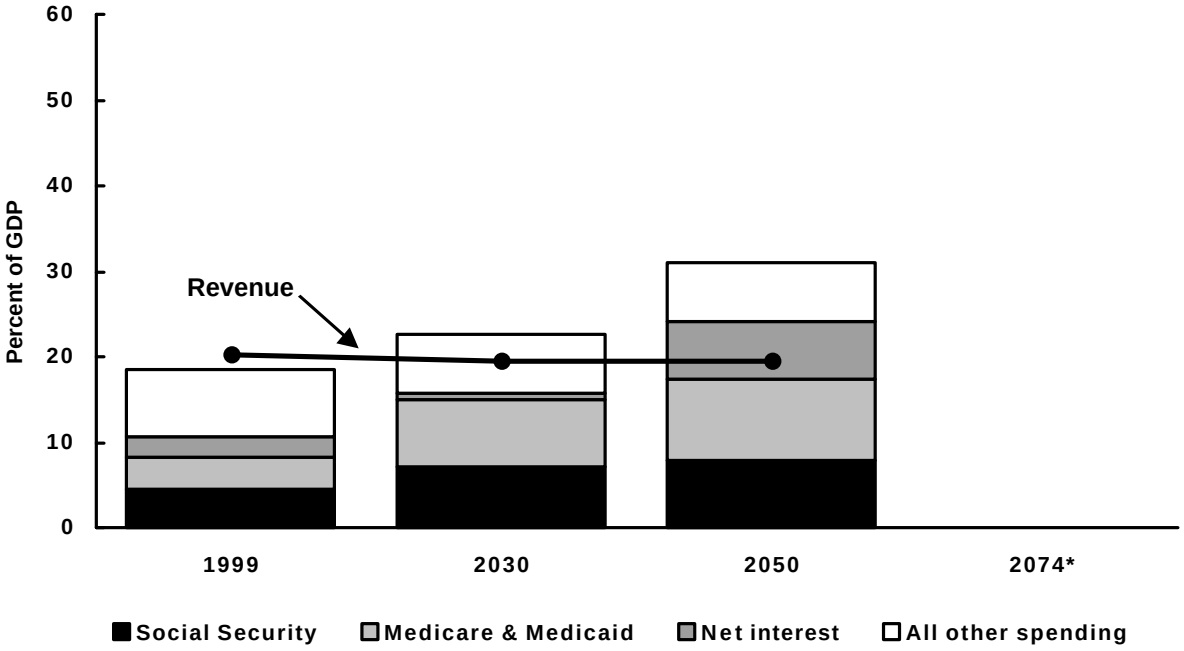
The progressive absorption of a greater share of the nation's resources for health care, like Social Security, is in part a reflection of the rising share of elderly population. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boomers. Today's elderly make up about 13 percent of the total population; by 2030, they will comprise 20 percent as the baby boom generation ages and the ratio of workers to retirees declines from 3.4 to 1 today to roughly 2 to 1.

However, Medicare growth rates also reflect the escalation of health care costs at rates well exceeding general rates of inflation. Increases in the number and quality of health care services have been fueled by the explosive growth of medical technology. Moreover, the actual costs of health care consumption are not transparent. Third-party payers generally insulate consumers from the cost of health care decisions. In traditional Medicare, for example, the impact of the cost-sharing provisions designed to curb the use of services is muted because about 80 percent of beneficiaries have some form of supplemental health care coverage (such as Medigap insurance) that pays these costs. For these reasons, among others, Medicare represents a much greater and more complex fiscal challenge than even Social Security over the longer term.

When viewed from the perspective of the entire budget and the economy, the growth in Medicare spending will become progressively unsustainable over the longer term. Our updated

budget simulations show that to move into the future without making changes in the Social Security, Medicare, and Medicaid programs is to envision a very different role for the federal government. Assuming, for example, that the Congress and the president adhere to the often-stated goal of saving the Social Security surpluses, our long-term model shows a world by 2030 in which Social Security, Medicare, and Medicaid increasingly absorb available revenues within the federal budget. Under this scenario, these programs would absorb more than three-quarters of total federal revenue. (See fig. 3.) Budgetary flexibility would be drastically constrained and little room would be left for programs for national defense, the young, infrastructure, and law enforcement.

Figure 3: Composition of Spending as a Share of GDP Under "Eliminate Non-Social Security Surpluses" Simulation



*The "Eliminate non-Social Security surpluses" simulation can only be run through 2066 due to the elimination of the capital stock.

Notes:

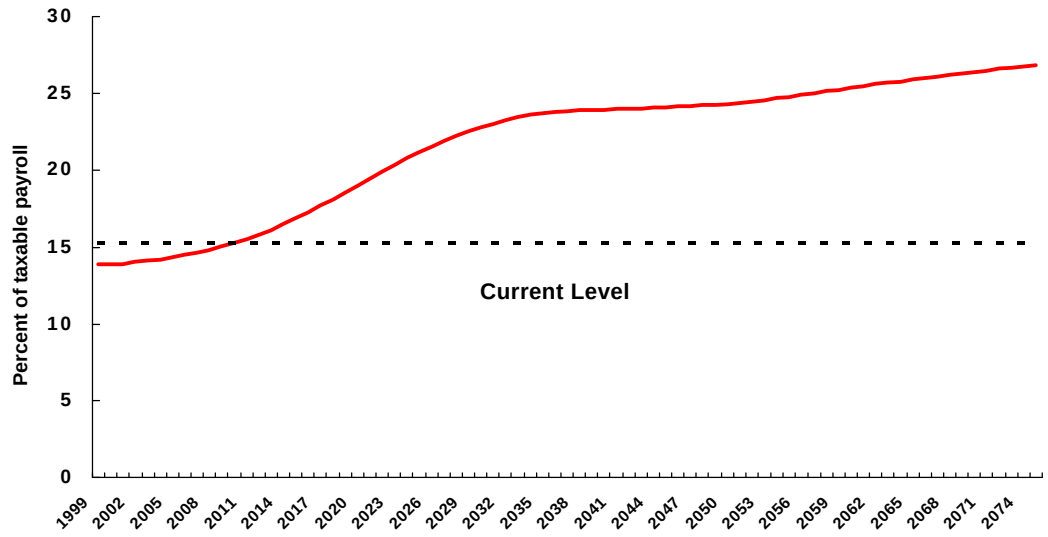
1. Revenue as a share of GDP during the simulation period is lower than the 1999 level due to unspecified permanent policy actions that reduce revenue and increase spending to eliminate the non-Social Security surpluses.

2. Medicare expenditure projections follow the Trustees' 1999 intermediate assumptions. The projections reflect the current benefit and financing structure.

Source: GAO's January 2000 analysis.

When viewed together with Social Security, the financial burden of Medicare on future taxpayers becomes unsustainable, absent reform. As figure 4 shows, the cost of these two programs combined would nearly double as a share of the payroll tax base over the long term. Assuming no other changes, these programs would constitute an unimaginable drain on the earnings of our future workers.

Figure 4: Social Security and Medicare HI as a Percentage of Taxable Payroll, 1999 to 2074



Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund, and *1999 Annual Report*, Board of Trustees of the Federal Old Age and Survivors Disability Insurance Trust Funds.

While the problems facing the Social Security program are significant, Medicare's challenges are even more daunting. To close Social Security's deficit today would require a 17 percent increase in the payroll tax, whereas the HI payroll tax would have to be raised 50 percent to restore actuarial balance to the HI trust fund. This analysis, moreover, does not incorporate the financing challenges associated with the SMI and Medicaid programs.

Early action to address the structural imbalances in Medicare is critical. First, ample time is required to phase in the reforms needed to put this program on a more sustainable footing before the baby boomers retire. Second, timely action to bring costs down pays large fiscal dividends for the program and the budget. The high projected growth of Medicare in the coming years means that the earlier the reform begins, the greater the savings will be as a result of the effects of compounding.

The actions necessary to bring about a more sustainable program will no doubt call for some hard choices. Some suggest that the size of the imbalances between Medicare's outlays and payroll tax revenues for the HI program may well justify the need for additional resources. One possible source could be general revenues. Such additional financing should be considered as part of a broader initiative to ensure the program's long-range financial integrity and sustainability.

What concerns me most is that devoting general funds to the HI trust fund may be used to extend HI's solvency without addressing the hard choices needed to make the whole Medicare program more sustainable in economic or budgetary terms. Increasing the HI trust fund balance

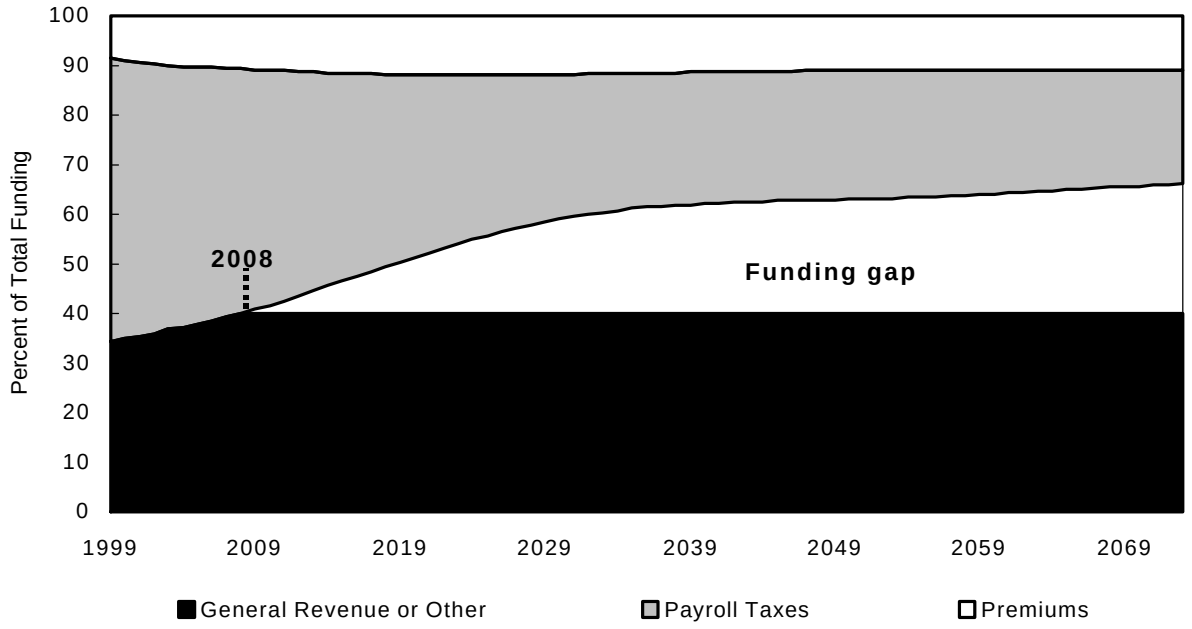
alone, without underlying program reform, does nothing to make the Medicare program more sustainable—that is, it does not reduce the program's projected share of GDP or the federal budget. From a macroeconomic perspective, the critical question is not how much a trust fund has in assets but whether the government as a whole has the economic capacity to finance all Medicare's promised benefits—both now and in the future.

If more fundamental program reforms are not made, I fear that general fund infusions would interfere with the vital signaling function that trust fund mechanisms can have for policymakers about underlying fiscal imbalances in covered programs. The greatest risk is that dedicating general funds to the HI program will reduce the sense of urgency that impending trust fund bankruptcy provides to policymakers by artificially extending the solvency of the HI program. Furthermore, increasing the trust fund's paper solvency does not address cost growth in the SMI portion of Medicare, which is projected to grow even faster than HI in coming decades.

The issue of the extent to which general funds are an appropriate financing mechanism for the Medicare program would remain important under financing arrangements that differed from those in place in the current HI and SMI structures. For example, under approaches that would combine the two trust funds, a continued need would exist for measures of program sustainability that would signal potential future fiscal imbalance. Such measures might include the percentage of program funding provided by general revenues, the percentage of total federal revenues or gross domestic product devoted to Medicare, or program spending per enrollee. As such measures were developed, questions would need to be asked about the appropriate level of general revenue funding as well as the actions to be taken if projections showed that program expenditures would exceed the chosen level.

For example, under the Breaux-Frist proposal, the HI and SMI trust funds would be merged and automatic general revenue financing would be limited to 40 percent of total program expenditures. Current spending projections show that absent substantive reform that addressed total program financing needs, this limit would be reached in less than 10 years. (See fig. 5.)

Figure 5: Projected Funding Gap Under a 40-Percent Cap in General Revenue Contributions



Source: *1999 Annual Report*, Board of Trustees of the Federal Hospital Insurance Trust Fund and *1999 Annual Report*, Federal Supplementary Insurance Trust Fund.

These data underscore the need for reform to include appropriate measures of fiscal sustainability as well as a credible process to give policymakers timely warning when fiscal targets are in danger of being overshot.

Long-Term Fiscal Policy Choices

Beyond reforming the Medicare program itself, maintaining an overall sustainable fiscal policy and strong economy is vital to enhancing our nation's future capacity to afford paying benefits in the face of an aging society. Decisions on how we use today's surpluses can have wide-ranging impacts on our ability to afford tomorrow's commitments.

As we know, there have been a variety of proposals to use the surpluses for purposes other than debt reduction. Although these proposals have various pros and cons, we need to be mindful of the risk associated with using projected surpluses to finance permanent future claims on the budget, whether they are on the spending or the tax side. Commitments often prove to be permanent, while projected surpluses can be fleeting. For instance, current projections assume full compliance with tight discretionary spending caps. Moreover, relatively small changes in economic assumptions can lead to very large changes in the fiscal outlook, especially when carried out over a decade. In its January 2000 report,[1] CBO compared the actual deficits or

[1] *The Economic and Budget Outlook: Fiscal Years 2001-2010* (CBO, Jan. 2000).

surpluses for 1986 through 1999 with the first projection it had produced 5 years before the start of each fiscal year. Excluding the estimated impact of legislation, CBO says that its errors in projecting the federal surplus or deficit averaged about 2.4 percent of GDP in the fifth year beyond the current year. For example, such a shift in 2005 would mean a potential swing of about $285 billion in the projected surplus for that year.

Although most would not argue for devoting 100 percent of the surplus to debt reduction over the next 10 years, saving a good portion of our surpluses would yield fiscal and economic dividends as the nation faces the challenges of financing an aging society. Our work on the long-term budget outlook illustrates the benefits of maintaining surpluses for debt reduction. Reducing the publicly held debt reduces interest costs, freeing up budgetary resources for other programmatic priorities. For the economy, running surpluses and reducing debt increase national saving and free up resources for private investment. These results, in turn, lead to stronger economic growth and higher incomes over the long term.

Over the last several years, our simulations illustrate the long-term economic consequences flowing from different fiscal policy paths.[2] Our models consistently show that saving all or a major share of projected budget surpluses ultimately leads to demonstrable gains in GDP per capita. Over a 50-year period, GDP per capita is estimated to more than double from present levels by saving all or most of projected surpluses, while incomes would eventually fall if we failed to sustain any of the surplus. Although rising productivity and living standards are always important, they are especially critical for the 21st century, for they will increase the economic capacity of the projected smaller workforce to finance future government programs along with the obligations and commitments for the baby boomers' retirement.

BBA Attempt to Moderate Medicare Spending Illustrates the Challenge of Reform

BBA reforms enacted in 1997 have begun to address certain outmoded programmatic shortcomings in Medicare by modernizing the program's pricing and payment strategies and by moving toward quality-based competition among health plans. The act's combination of structural reforms, constraints on provider fees, and increases in beneficiary payments have already contributed to slowing program spending. However, the full effects of these changes on providers, beneficiaries, and taxpayers will not be known for some time.

One significant change was BBA's creation of the Medicare+Choice program, which furthered the use of a choice-based model of providing Medicare benefits. Medicare+Choice expanded Medicare's managed care options to include, in addition to health maintenance organizations (HMO), health plans such as preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans. By expanding consumer choice in the program, BBA provisions placed a dramatic new emphasis on the development and dissemination of comparative plan information to consumers to foster quality-based plan competition. Other

[2]See *Budget Issues: Long-Term Fiscal Outlook* (GAO/T-AIMD/OCE-98-83, Feb. 25, 1998) and *Budget Issues: Analysis of Long-Term Fiscal Outlook* (GAO/AIMD/OCE-98-19, Oct. 22, 1997).

BBA provisions were designed to pay health plans more appropriately than Medicare had done under the previous HMO payment formula.

BBA also made historic changes to traditional Medicare. It is gradually eliminating, for the most part, cost-based reimbursement methods and replacing them with prospective payment systems (PPS). The intent is to foster the more efficient use of services and to lower growth rates in spending for affected providers, replicating the experience for acute care hospitals after the implementation of Medicare's PPS for hospitals, which began in the mid-1980s. BBA mandated phasing in PPSs for skilled nursing facilities, home health agencies, hospital outpatient services, and certain hospitals not already paid under such arrangements.

The recent experience in attempting to implement BBA provisions is instructive. The outcry from providers to undo BBA reforms aimed at savings and efficiency was intense. In response, the Congress made refinements. Time will determine what more is needed to make Medicare a prudent and efficient purchaser of health care services. Initial provider reactions to CBO's new baseline do not bode well for attempts to remain fiscally disciplined. However, the expectations of special interests should not be given excessive weight in determining the appropriate level of Medicare spending.

DIMENSIONS OF REFORM INCLUDE BENEFIT EXPANSIONS AND FINANCING CHANGES

Concern continues to be voiced about the obvious gaps in protections for Medicare beneficiaries, in contrast to what is available for most individuals with private employer-based coverage. At the same time, competing concerns remain about the need to check Medicare's cost growth. In response, proposals for Medicare reform have addressed one or both of the following two major dimensions: expansion of Medicare's benefit package and cost containment through financing and other structural transformations.

Benefit Expansion Reforms

Two commonly discussed benefit expansions are the inclusion of an outpatient prescription drug benefit and coverage for extraordinary out-of-pocket costs, known as catastrophic or stop-loss coverage. Today's Medicare benefit package largely reflects the offerings of the commercial insurance market in 1965 when the program began. Although commercial policies have evolved since then, Medicare's package—for the most part—has not.[3] For example, unlike many current commercial policies, Medicare does not cover outpatient prescription drugs or cap beneficiaries' annual out-of-pocket spending. Most beneficiaries augment their coverage by participating in the Medicaid program (if their incomes are low enough), obtaining a supplemental insurance policy privately or through an employer, or enrolling in a Medicare+Choice plan. About a third

[3]Some Medicare benefits have changed. For example, BBA added or expanded coverage for screening mammograms, prostate cancer screening tests, bone mass measurements, and several other screening or preventive services.

have no outpatient drug coverage. Consequently, many reform advocates believe that Medicare's basic benefit package should be brought into line with current commercial norms for active workers.

The inclusion of prescription drugs and stop-loss coverage each involve myriad options, and assessing the merit of these added benefits would depend on the specifics involved. For instance, how would these new program costs be shared between taxpayers and beneficiaries through premiums, deductibles, and copayments? Would subsidies be targeted to help low-income beneficiaries not eligible for Medicaid with these costs? Would incentives be needed to prevent a public drug benefit from crowding out private financing? The administration of the benefit raises other questions, such as who would set and enforce drug coverage standards among the private health plans participating in Medicare and, for traditional Medicare, how payment rates would be set.

Financing and Other Structural Reforms

In addition to benefit expansion, financing and structural elements of the following three general approaches appear in various proposals to reform Medicare:

- Fee-for-service modernization, which could enable traditional Medicare to act as a prudent purchaser and exercise better control over use of services.

- Medicare+Choice modernization, which would encourage plans to compete on cost as well as quality .

- A premium support system fashioned after the Federal Employees Health Benefits Program (FEHBP), which is designed to make beneficiaries sensitive to the cost implications of choosing a particular plan.

Table 2 highlights elements of each approach.

Table 2: Three Approaches to Medicare Financing and Structural Reforms

	Fee-for-service modernization	Medicare+Choice modernization	FEHBP-type premium support
Examples of changes mandated by BBA	• Prospective payment systems for home health agencies, skilled nursing facilities, and others	• Health-based risk adjustment of rates • Annual enrollment and lock-in • Competitive pricing demonstration	
Examples of proposed reforms	• Selective purchasing • Negotiated pricing • Case management for complex and chronic conditions • Utilization management • Medigap and beneficiary cost-sharing reforms • Expanded use of centers of excellence	• Plan savings shared with program or beneficiaries • Competitive premium pricing	• Premium based on offered or negotiated price • Beneficiary contribution based on plan cost • Traditional Medicare incorporated as competing plan

Fee-for-Service Modernization

BBA improved the efficiency of Medicare's traditional fee-for-service program by substituting prospective rates for its cost-based reimbursement methods. Nevertheless, Medicare is still not an efficient purchaser. Adequately adjusting its systems of administered prices and fees up or down to ensure beneficiary access or to capture potential savings as the market changes poses an overwhelming, if not impossible, challenge. Medicare largely remains a passive bill payer, exercising little meaningful control over the volume of services used. Proposals to modernize fee-for-service Medicare aim at providing flexibility to take advantage of market prices and introducing some management of service utilization. Below are several elements of this proposed type of approach.

Flexibility in setting payment rates. Preferred provider arrangements, whereby insurers select certain providers because of their willingness to accept lower fees or their efficient style of practice, have become commonplace in the commercial insurance market. By accepting negotiated or competitively bid fees that fall below the usual levels, selected providers and the beneficiaries using their services would be afforded certain advantages. The selected providers may experience increased demand, while beneficiaries using their services could be subject to lower cost-sharing. Comparable arrangements have been proposed for fee-for-service Medicare. Testing of this concept has been under way in the HCFA's Centers of Excellence demonstrations, where hospitals and physicians agree to provide certain procedures for negotiated all-inclusive fees. BBA also allowed for testing of competitive bidding for medical equipment and supplies, with high bidders being excluded from serving Medicare beneficiaries.

Increase in beneficiary cost-consciousness. While cost-sharing has been common in private insurance to make beneficiaries sensitive to the value and cost of services, it has been a cost-

containment tool largely unavailable to Medicare. Traditional Medicare includes some cost-sharing in the form of deductibles or copayments for services, but about 87 percent of beneficiaries are insulated from these costs by virtue of their eligibility for Medicaid or their enrollment in a supplementary insurance plan, such as Medigap. If reforms reduced these cost-sharing protections, beneficiaries would become more aware of the cost consequences of their health care decisions. At the same time, however, beneficiaries with high health care needs or limited resources could face financial hardships. Shielding these beneficiaries from such an outcome could involve placing an income-adjusted limit on beneficiary out-of-pocket expenses.

Utilization management. Private indemnity insurers have moved to incorporate certain utilization management techniques into their policies, such as prior authorization of some expensive services and case management for people with serious chronic conditions. Although such techniques are increasingly common among private insurers, Medicare has not incorporated them into its design.

Medicare+Choice Modernization

Medicare+Choice signaled a new phase in efforts to transform Medicare. Built on the program that allowed beneficiaries to enroll in participating managed care plans, Medicare+Choice sought to expand options available to beneficiaries and substantially changes plan payment methods. By raising payments in certain areas and allowing additional types of entities to contract with Medicare, Medicare+Choice was intended to boost plan participation and beneficiary enrollment.[4] Payment changes were designed to adjust the per capita rates to more accurately reflect enrollees' expected resource use and slow the growth of spending over time. Following are key elements of the Medicare+Choice modernization approach.

Payments adjusted for beneficiary health status. Among other payment changes, BBA required HCFA to implement by January 1, 2000, a methodology to adjust plan payments to reflect the health status of plan members. Favorable selection—that is, the tendency for healthier beneficiaries to enroll in managed care plans—had resulted in payments that are higher than warranted. The new risk adjustment method developed for Medicare will more closely align payments with the expected health care costs of plans' enrollees. This alignment is expected to help produce the savings originally envisioned when managed care enrollment options were offered to Medicare beneficiaries and can foster competition among plans on the basis of benefits and quality rather than enrollment strategies.

Competition harnessed to benefit taxpayers. The Medicare+Choice program could be modified, through new legislation, to require that taxpayers and beneficiaries both benefit from health plan competition. Under the current Medicare+Choice program, taxpayers do not benefit from the competition among health plans. If a plan can provide the Medicare package of benefits for less than the Medicare payment, it must cover additional benefits, reduce beneficiary cost- sharing,

[4]Plan participation has fallen since BBA's Medicare+Choice provisions took effect. This decline may be more the result of external market forces than changes in Medicare's payment policy. See *Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals, Plan Interest Continues* (GAO/HEHS-99-91, Apr. 27, 1999).

or both.[5] Beneficiaries gain from competition among plans because these plans often offer enriched benefits—such as including coverage for outpatient prescription drugs or routine physical examinations—to increase market share. The program does not share in these gains, however, because it pays plans a formula-driven amount, even in fiercely competitive markets.

One modification the Congress could make would be to require that when payments exceed a plan's cost of services (including reasonable profit), part of the savings be returned to the program and the rest be used to fund additional benefits. Another alternative would be to set plan payments through competitive bidding. In fact, BBA mandates a competitive pricing demonstration. However, setting the parameters of a competitive pricing system is a formidable task. Furthermore, this payment-setting approach is probably best suited to urban areas with high concentrations of managed care members.

FEHBP-Type Premium Support

Although modernizing traditional Medicare and Medicare+Choice could improve the control of program spending, several incentives would remain unaltered. For example, beneficiaries would remain largely insulated from the cost consequences of their choices. They would not benefit directly from selecting plans that deliver Medicare-covered benefits less expensively because the premiums they pay might well remain constant. Program payments to plans would continue to be established administratively. To address this situation, proposals fashioned after the premium support model are designed to increase beneficiary sensitivity to the cost consequences of their choices and enhance quality-and-cost-based competition.

The two defining elements of an FEHBP-type of premium support are (1) the establishment of premium levels for plans through a competitive process and (2) the linking of beneficiaries' contributions to the premiums of the plans they join. This system makes transparent to beneficiaries which plans operate less expensively and can therefore charge lower premiums. The cost-slowing theory behind this approach works as follows: competition encourages efficiency because plans that can reduce costs can lower premiums and attract more enrollees. If these plans can attract beneficiaries with their lower premiums, enrollment in the more costly plans would drop, thus lowering the government's spending on Medicare. In practice, some caveats remain. Differences in premiums can reflect more than variation in efficiency. For example, plans may achieve savings through narrower provider networks that, while capable of providing Medicare-covered benefits, could cause beneficiaries inconveniences and delays in accessing services.

[5]Alternatively, plans can contribute to a stabilization fund that would allow them to provide additional benefits or lower fees in future years. Before BBA, health plans also had the option of accepting a lower capitation payment. In practice, plans preferred to add benefits to attract beneficiaries.

Breaux-Frist Proposal Includes Elements of Modernization and Premium Support Approaches

The Breaux-Frist proposal includes elements from each of the structural and financing approaches discussed. Building on the premium-support concepts embedded in FEHBP, it replaces the current system in which each beneficiary pays a fixed monthly part B premium to the government and potentially an additional premium to a Medicare managed care plan. Under Breaux-Frist, each plan determines its own premium for a benefit package that must cover all benefits offered by traditional Medicare. The percentage of the premium paid by the beneficiary is set through a formula that compares a plan's premium with a national average of all plan premiums. Beneficiaries who join relatively inexpensive plans pay little or nothing. Those who join relatively expensive plans pay more. The system is intended to make beneficiaries more sensitive to the cost consequences of their decisions. Because plans would compete for market share, they would have an incentive to operate efficiently and attract beneficiaries by setting premiums that reflect that efficiency.

The proposal also seeks to modernize Medicare's benefit package by providing outpatient prescription drug and stop-loss benefits. Specifically, all participating entities would be required to offer a high-option plan that includes a specified amount of prescription drug coverage and protection against large out-of-pocket costs for the traditional Medicare benefits. The government would fully subsidize the purchase of a high-option plan for low-income beneficiaries and partially subsidize it for all others, thus providing a targeted benefit. Traditional fee-for-service Medicare, operated by HCFA, would exist as a standard option plan and remain available to all beneficiaries. The monthly amount charged to beneficiaries, analogous to the current part B premium, would be determined using the same formula applied to private plans. Alternatively, beneficiaries could purchase a high-option HCFA-sponsored plan.

IMPLEMENTING MEDICARE REFORM INVOLVES MULTIPLE CHALLENGES

The challenge of implementing Medicare reforms must be respected. As we have noted before, to determine the likely impact of a particular policy, details matter. Design choices and implementation policies can affect the success of proposed reforms. In addition, because difficult choices tend to meet with opposition from affected parties, the will to stay the course is equally important for successful reform. Following are just a few of the issues germane to Medicare reform that remind us of the proverb, "The devil is in the details."

Adjusting Premiums to Avoid Putting Beneficiaries and Plans at a Disadvantage

For proposals that include elements of premium support, the task of determining the government's contribution toward each plan's premium raises several technical issues. In general, the government's share is greater or smaller, depending on whether the plan's premium is below or above the average of all plan premiums. However, some plans can incur higher-

than-average expenses because they enroll a disproportionate number of more seriously ill and costly beneficiaries or because of local market conditions outside of their control. Unless the government contribution is adjusted for these circumstances, beneficiaries would face higher out-of-pocket costs and plans would be at a competitive disadvantage.

For example, most FEHBP-type reform proposals recognize the need to "risk adjust" the government contribution to reflect beneficiary health status. Such an adjustment enables plans to be fairly compensated when they enroll either healthier or sicker-than-average beneficiaries. The Medicare+Choice program is phasing in an interim risk-adjustment methodology based on the limited health status data currently available. The challenge, for Medicare+Choice or any premium-based reform proposal, is to implement an improved method that more accurately adjusts payments, does not impose an undue administrative burden on plans, and cannot be manipulated by plans seeking to inappropriately increase revenues.

An adjustment for differences in local medical prices is also desirable under a premium support system. Without it, premiums in high-price areas will tend to be above the national average. Adjusting the government contribution for input price differences can help ensure fair price competition between local and national plans and avoid having beneficiaries pay a higher premium, or higher share of a premium, simply because they live in a high-price area.

Finally, the use of medical services varies dramatically among communities because of differences in local medical practices. Under premium support approaches, plan premiums in high-use areas will likely exceed the national average. Whether, or to what extent, to adjust the government contribution for this outcome is a matter of policy choice. On the one hand, without an adjustment, beneficiaries living in high-use areas who join local private plans could face substantial out-of-pocket costs for circumstances outside of their control. Consequently, private plans in these areas might have difficulty competing with a HCFA-sponsored plan that charged a fixed national premium based on an overall average of medical service use. On the other hand, there have been longstanding concerns about unwarranted variations in medical practice. By not adjusting the government contribution for utilization differences, financial pressures could encourage providers to reduce inappropriate levels of use.

Determining the Role of the Entity
That Administers the Program

Medicare's administrative functions include the oversight of plans' contracts. In today's Medicare program, this function is performed by HCFA; in FEHBP, by the Office of Personnel Management; under Breaux-Frist, by a quasi-independent Medicare board.

Whatever the administrative entity is under Medicare reform, the following are questions that policymakers will want to consider. First, how will the administrative entity's mission be defined? Will the emphasis be on controlling costs, protecting beneficiaries, maximizing choice, or some combination of these goals? Policy choices would flow from the stated mission. Second, how much independence would be permitted to the administrative entity to carry out its mission? Would it be appropriately shielded from the pressure exerted by special interest

groups? Third, how would the administrative entity hold plans accountable for meeting Medicare standards? Would it rely chiefly on public accountability, in which the process and procedures for compliance are clearly defined and actively monitored, or on market accountability, by providing comparative information on competing plans and letting beneficiary enrollment choices weed out poor performers?

Incorporating Traditional Medicare as a Competing Plan

Incorporating traditional Medicare as another competing plan raises a number of questions. How much flexibility can be granted to traditional Medicare, which today enrolls 83 percent of all Medicare beneficiaries? Will it be able to adopt modern management techniques—such as selectively contracting with providers—given its potential market power? What will it mean for a public plan to be self-sustaining and self-financing? Can it generate and retain reserves as a protection against future losses? How will losses be managed? The insolvency of traditional Medicare, which may continue to enroll the majority of beneficiaries and may be the only plan serving many areas of the country, is not acceptable. The dilemma of how to guarantee traditional Medicare's solvency in the context of an FEHBP-type premium support system needs to be addressed.

CONCLUDING OBSERVATIONS

In determining how to reform the Medicare program, much is at stake—not only the future of Medicare itself but also assuring the nation's future fiscal flexibility to pursue other important national goals and programs. Mr. Chairman, I feel that the greatest risk lies in doing nothing to improve the program's long-term sustainability or, worse, in adopting changes that may aggravate the long-term financial outlook for the program and the budget.

It is my hope that we will think about the unprecedented challenge facing future generations in our aging society. Relieving them of some of the burden of today's financing commitments would help fulfill this generation's fiduciary responsibility. It would also preserve some capacity to make their own choices by strengthening both the budget and the economy they inherit**.** While not ignoring today's needs and demands, we should remember that surpluses can be used as an occasion to promote the transition to a more sustainable future for our children and grandchildren.

General fund infusions and expanded benefits may well be a necessary part of any major reform initiative. Updating the benefit package may be a necessary part of any realistic reform program to address the legitimate expectations of an aging society for health care, both now and in the future. Such changes, however, need to be considered as part of a broader initiative to address Medicare's current fiscal imbalance and promote the program's longer-term sustainability. In addition, the Congress should consider adequate fiscal incentives to control costs and a targeting strategy in connection with any proposal to provide new benefits such as prescription drugs.

I am under no illusions about how difficult Medicare reform will be. The Breaux-Frist proposal addresses the principal elements of reform, but many of the details need to be worked out. Those details will determine whether reforms will be both effective and acceptable—that is, seen as guaranteeing the sustainability and preservation of the Medicare entitlement, a key goal on which there appears to be consensus. Experience shows that forecasts can be far off the mark. Benefit expansions are often permanent, while the more belt-tightening payment reforms—vulnerable to erosion—could be discarded altogether. Recent experience implementing BBA reforms provides us some sobering lessons about the difficulty of undertaking reform and the need for effectiveness, flexibility, and steadfastness. Effectiveness involves collecting the data necessary to assess impact-separating the transitory from the permanent and the trivial from the important. Flexibility is critical to make changes and refinements when conditions warrant and when actual outcomes differ substantially from the expected ones. Steadfastness is needed when particular interests pit the primacy of their needs against the more global interest of making Medicare affordable, sustainable, and effective for current and future generations of Americans. This makes it all the more important that any new benefit expansion be carefully designed to balance needs and affordability, both now and over the longer term.

The bottom line is that surpluses represent both an opportunity and an obligation. We have an opportunity to use our unprecedented economic wealth and fiscal good fortune to address today's needs but an obligation to do so in a way that improves the prospects for future generations. This generation has a stewardship responsibility to future generations to reduce the debt burden they will inherit, to provide a strong foundation for future economic growth, and to ensure that future commitments are both adequate and affordable. Prudence requires making the tough choices today while the economy is healthy and the workforce is relatively large. National saving pays future dividends over the long term but only if meaningful reform begins soon. Entitlement reform is best done with considerable lead time to phase in changes and before the changes that are needed become dramatic and disruptive. The prudent use of the nation's current and projected budget surpluses combined with meaningful Medicare and Social Security program reforms can help achieve both of these goals.

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Mr. Chairman and Members of the Committee, this concludes my prepared statement. I will be happy to answer any questions you may have.

GAO CONTACTS AND ACKNOWLEDGMENTS

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